

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155199		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN 46074			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/18/12</p> <p>Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Maple Park Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility does not have smoke detectors in resident sleeping rooms. The</p>			K0000	<p>May 8 th 2012 Dear Kim Rhoades, Please find the attached Plan of Corrections for the Life Safety Code Recertification and State Licensure survey performed on April 18, 2012 . The provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. Sincerely, Zach Krumwied, HFAExecutive DirectorMaple Park Village The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PRINTED: 05/17/2012

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OMB NO. 0938-0391

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	<p>facility has a capacity of 106 and had a census of 97 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/20/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 1 of 5 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could any resident, staff or visitor at the smoke barrier door set near the Hall 2 Nurse's station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the</p>		K0025	<p>K 025 No residents were identified as being affected. There were no residents affected. However, residents on hall 200 had the potential to be affected. The hole in the smoke barrier above the hall 200 nurse station has been properly filled and sealed to maintain the resistance of smoke. All smoke barriers were checked and proper smoke resistance is maintained. Smoke barriers will be checked after work is completed by all vendors and facility staff to ensure that any hole created is properly sealed. Compliance date: 5.15.2012</p>		05/15/2012	

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	<p>facility from 10:25 a.m. to 12:40 p.m. on 04/18/12, the attic smoke barrier wall above the ceiling above the smoke barrier door set near the Hall 2 Nurse's station had a three inch in diameter hole in the wall where two cables passed through the wall which was not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged there is a three inch diameter hole in the attic smoke barrier wall above the ceiling above the smoke barrier door set near the Hall 2 Nurse's station.</p> <p>3.1-19(b)</p>						

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 9 doors serving hazardous areas such as the kitchen is provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the east kitchen entry door.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:25 a.m. to 12:40 p.m. on 04/18/12, the east kitchen entry door is not equipped with a self closing device which would cause the door to automatically close and latch into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the east kitchen</p>		K0029	<p>K029No residents were identified as being affected. There were no residents affected. However all residents have the potential to be affected. The kitchen door identified has been equipped with a self-closing device which will cause the door to automatically close and latch into the door frame. Doors serving hazardous areas will be provided with self-closing devices which will cause the door to automatically close and latch. The maintenance director will check the doors 1 time a month to ensure proper function of the self closing device. Compliance date: 5.15.2012</p>		05/15/2012	

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	<p>entry door is not equipped with a self closing device which would cause the door to automatically close and latch into the door frame.</p> <p>3.1-19(b)</p>						

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 5 of 11 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects any resident, staff or visitor needing to exit the facility by Room 307, Room 225, Therapy Room, the Dining Room by Room 210 and the Service Corridor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:25 a.m. to 12:40 p.m. on 04/18/12, eleven exit doors were</p>			K0038	<p>K038 No residents were identified as being affected. There were no residents affected. However, all residents have the potential to be affected. Four digit exit codes are posted at exit doors by room 307, room 225, the therapy room, the dining room by room 210, and the entry door to the service corridor. Exit doors will be checked 1 time a month by the Maintenance director to ensure that four digit codes are posted. Compliance date: 5.15.2012</p>		05/15/2012

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	<p>magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit door by Room 307, Room 225, the Therapy Room, the Dining Room by Room 210 and the entry door to the Service Corridor exit. Based on interview with the Maintenance Director at the time of the observations, the residents who have a clinical diagnosis to be in a secure building are housed in the secure 100 Hall, and not near the aforementioned facility exits. The Maintenance Director went on to say, a resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the exit access code. Based on interview at the time of the observations, the Maintenance Director acknowledged the four digit exit code was not posted at the facility exit by Room 307, Room 225, Therapy Room, the Dining Room by Room 210 and the entry door to the Service Corridor exit.</p> <p>3.1-19(b)</p>						

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K0048 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "General Action Fire Plan" during record review with the Maintenance Director from 9:20 a.m. to 10:25 a.m. on 04/18/12, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire</p>	K0048	<p>K048No specific residents were mentioned.All residents have the potential to be affected. The written safety plan has been updated to address the use of the overhead extinguishing system prior to the of an ABC fire extinguisher or k class fire extinguisher. The written safety plan has been updated to address the use of the overhead extinguishing system in the kitchen to suppress a fire prior to the use of an ABC fire extinguisher or k class fire extinguisher.The maintenance director will review the written safety plan 1 time per month to ensure that the updated plan is included. Compliance date: 5.15.12</p>	05/15/2012			

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	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>						

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.</p>			K0052	<p>K052 No residents were listed as being affected. No specific residents were listed as being affected. However, all residents have the potential to be affected. The breaker referenced in the 2567 was locked. The maintenance director will check the panel weekly to ensure that it is locked. Completion date: 05/15/2012</p>		05/15/2012

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:25 a.m. to 12:40 p.m. on 04/18/12, access to the fire alarm system breaker located in the Fire Panel room in Dietary was not locked. Based on interview at the time of observation, the Maintenance Director acknowledged access to the fire alarm system breaker located in the Fire Panel room in Dietary was not locked.</p> <p>3.1-19(b)</p>						

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K0067 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review, observation and interview; the facility failed to ensure 7 of 8 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects 97 of 97 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:25 a.m. to 12:40 p.m. on 04/18/12, the facility has three fire dampers located in the HVAC system in</p>			K0067	<p>K067 No specific residents were listed as being affected All residents had the potential to be affected. The 3 fire dampers identified in the HVAC system in the mechanical room by the front lobby and the 4 fire dampers located in the mechanical room by dietary will be inspected and replaced. The fire dampers will be inspected and replaced every 4 years. The maintenance director will keep record of the inspections and replacement of all applicable fire dampers and ensure that each is replaced every 4 years at minimum. Compliance date: 05/15/12</p>		05/15/2012

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	<p>the Mechanical Room by the front lobby and the facility has four fire dampers located in the HVAC system in the Mechanical Room by Dietary for which no record of the installation date or fusible link replacement date was recorded on or near the fire damper. Based on record review with the Maintenance Director from 9:20 a.m. to 10:25 a.m. on 04/18/12, documentation of maintenance records of fire damper inspection and the necessary maintenance provided at least every four years was not available for review. Based on interview at the time of record review and the observations, the Maintenance Director acknowledged documentation was not available for review for seven of eight fire dampers located in the facility demonstrating fusible links had been removed and replaced every four years.</p> <p>3.1-19(b)</p>						

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K0154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 97 of 97 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch Policy and Procedure" documentation with the</p>			K0154	<p>K154 No residents were identified as being affected. All residents have the potential to be affected. The fire watch policy has been amended to include the notification of the Indiana State Dept. of Health, the alarm company, the local fire department, and building owner/manager, in the event that the automatic sprinkler system has to be placed out of service for 4 or more hours in a 24 hour period. The maintenance director will perform checks monthly to ensure that the amended policy is in the emergency disaster manual Compliance date: 05/15/12</p>		05/15/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155199		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/18/2012	
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN 46074			
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	<p>Maintenance Director during record review from 9:20 a.m. to 10:25 a.m. on 04/18/12, "Procedure" states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the necessary entities, which includes the Indiana State Department of Health, alarm company, local fire department, and building owner/manager, would be notified in the event of a fire. Based on interview at the time of observation, the Maintenance Director stated the facility's written fire watch policy requires notification of the necessary entities in the event of a fire and acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health, alarm company, local fire department, and building owner/manager in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period.</p> <p>3.1-19(b)</p>						

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K0155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 97 of 97 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch Policy and Procedure" documentation with the Maintenance Director during record review from 9:20 a.m. to 10:25 a.m. on 04/18/12, "Procedure" states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the authorities having jurisdiction, the Indiana State Department of Health and the local fire department, would be notified in the event of a fire. Based on interview at the time of</p>		K0155	<p>K155 No residents were identified as being affected. All residents have the potential to be affected. The fire watch policy has been amended to include the notification of the Indiana State Dept. of Health, the alarm company, the local fire department, and building owner/manager, in the event that the fire alarm system has to be placed out of service for 4 or more hours in a 24 hour period. The maintenance director will perform checks monthly to ensure that the amended policy is in the emergency disaster manual Compliance date: 05/15/12</p>		05/15/2012	

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	<p>observation, the Maintenance Director acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health and the local fire department would occur in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period.</p> <p>3.1-19(b)</p>						